Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**

- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**

- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**

- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

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FRAMEWORK FOR ANNUAL REPORT
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State/Territory: Wisconsin
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): BadgerCare

SCHIP Program Type:

- X Medicaid SCHIP Expansion Only
- ___ Separate SCHIP Program Only
- ___ Combination of the above

Reporting Period: **Federal Fiscal Year 2001 (October 1, 2000 – September 30, 2001)**

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Submission Date: January 1, 2002

This section has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 – October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "N/C" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility

The asset test was eliminated and verification requirements reduced for Title XIX applications.

B. Enrollment process

Effective July 1, 2001, a mail-in/phone-in application process was implemented.

C. Presumptive eligibility

N/C

D. Continuous eligibility

N/C

E. Outreach/marketing campaigns

1. Robert Wood Johnson Foundation project in Wisconsin (one of 50 state projects) with ABC for Health as the project lead, and supplemental funding by DHFS, was created as a statewide network building project with community organizations and health care providers as well as agencies that assist populations with language barriers.

2. A two-year project (through December 2002), funded by DHFS, Dane County, and local health care providers, was created to assist with outreach efforts for target groups, focusing on the growing Latino population in Dane

County and to provide enrollment assistance to other underinsured groups, including adolescents and higher income families.

3. Automated Health Systems is providing statewide training to community organizations and health care providers on Medicaid and BadgerCare program simplification initiatives.

F. Eligibility determination process

Effective July 1, 2001, a reduced verification process was implemented.

G. Eligibility redetermination process

N/C

H. Benefit structure

N/C

I. Cost-sharing policies

N/C

J. Crowd-out policies

N/C

K. Delivery system

N/C

L. Coordination with other programs (especially private insurance and Medicaid)

N/C

M. Screen and enroll process

Effective July 1, 2001, a mail-in/phone-in application process was implemented.

N. Application

A simplified, one-page application was implemented on January 1, 2001.

P. Other

The application is offered in Spanish, Hmong, Russian, and customer notices were improved.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

September 2001, (Update) – BadgerCare enrollment as of September 30, 2001, included 25,538 children who were previously uninsured, and 2,499 low-income teenagers (OBRA). The total number of children with health coverage under BadgerCare was 28,037. An additional 54,347 children were brought into Medicaid Healthy Start as a result of BadgerCare. Therefore, an additional 82,384 children received health care coverage as a result of BadgerCare.

BadgerCare Enrollment/BadgerCare Eligible Remaining Uninsured
As of September 30, 2001

	Adults*	Children	Total
Uninsured Under 200% of FPL (Based on 2000 FHS Sample)*	61,000	39,000	100,000
Enrolled in BadgerCare	60,875	25,538	86,413
Low Income Teenagers (OBRA Expansion)		2,499	2,499
Total BadgerCare	60,875	28,037	88,912
Increased Medicaid Healthy Start Children due to BadgerCare Outreach and BadgerCare/ Medicaid Coordination		54,347	54,347
Total BadgerCare and Medicaid Increase	60,875	82,384	143,259
As percentage of uninsured under 200% FPL*	99.8%	100%**	100%**
Estimated BadgerCare Eligible Remaining Uninsured	125	0	125
As percentage of uninsured under 200% FPL	0.20%	100%**	0.13%

* Only includes adults in families with low-income children.

** Percentage may be somewhat more or less than 100 percent because the estimate of the statewide population of uninsured low-income children is based on a sample from 2000.

Net BadgerCare Enrollment/BadgerCare Eligible Remaining Uninsured In FFY 2001

	Adults*	Children	Total
Uninsured Under 200% of FPL (Based on 2000 FHS Sample)*	61,000	39,000	100,000
Enrolled in BadgerCare	10,248	5,167	15,415
Low Income Teenagers (OBRA Expansion)		-1,250	-1,250
Total BadgerCare in FFY 01	10,248	3,917	14,165
Increased Medicaid Healthy Start Children due to BadgerCare Outreach and BadgerCare/ Medicaid Coordination in FFY 01		31,384	31,384
Total BadgerCare and Medicaid Increase in FFY 01	10,248	35,301	45,549
As a percentage of uninsured under 200% FPL in FFY 01	16.8%	90.5%	45.5%
Estimated BadgerCare Eligible Remaining Uninsured	125	0	125
As percentage of uninsured under 200% FPL	.2%	100%**	0.1%

* Based on the most recent Family Health Survey data for 2000. It is estimated that there were 39,000 uninsured children living in households with income below 200 percent of the FPL.

** Percentage may be somewhat more or less than 100 percent because the estimate of the statewide population of uninsured low-income children is based on a sample from 2000.

Progress in reducing the number of uninsured children since September 2001
Since September 2001 through November 2001, an additional 1,733 children have enrolled in BadgerCare; an additional 453 children have enrolled in Medicaid; and an additional 968 adults have enrolled in BadgerCare.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

As a result of SCHIP outreach and enrollment simplification, 54,347 children enrolled in Medicaid since July 1999. The data source for this number is the CARES Management Information System, which tracks all enrollment and disenrollment statistics for Medicaid and BadgerCare.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

During the 29 months of enrollment, a total of 84,165 children have received health care coverage as a result of BadgerCare. Since the implementation of BadgerCare, an additional 54,800 children have been enrolled in Medicaid.

According to the *Wisconsin Health Insurance Coverage 2000,* 30,000 children 0-17 years of age, remain uninsured in Wisconsin. This represents 2 percent of the state population in this age category.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

____ No, skip to 1.3

_X_ Yes, what is the new baseline?
Based on a 1997 and 1998 Family Health Survey Sample, the original baseline was estimated at 54,000 uncovered, low-income children. Based on a 2000 Family Health Survey, the baseline was re-estimated at 39,000 uncovered, low-income children.

What are the data source(s) and methodology used to make this estimate?

The State has utilized the most current Family Health Survey sample available to produce the estimated baseline. The FHS was began 1989, and is conducted on a continuous basis, collecting information every month. The survey is conducted by trained interviewers who speak with the household member most knowledgeable about the health and insurance coverage of all household members.

The survey results are representative of Wisconsin household residents, who constitute approximately 97 percent of all persons residing in the state. Non-household residents, including persons living in nursing homes, dormitories, prisons, and other institutions constitute the remaining 3 percent who are not represented in the survey.

What was the justification for adopting a different methodology?

A more recent sample was used.

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The Confidence Interval for the estimated baseline is (+/-) 15,000.

The baseline estimate represents estimated number of uninsured low-income children based on survey responses. The estimate should not be treated as a precise result as it is derived from a sample.

The Wisconsin Family Health Survey uses a larger random sample for Wisconsin than does equivalent uninsured data from the Census Bureau. In addition, the FHS specifically asks questions about being uninsured, unlike the Census Bureau. The Census Bureau arrives at its estimate through the residual method, which simply assumes that anyone who did not report having health insurance is actually uninsured. The lack of a direct question about being uninsured is a serious omission, which can result in an overestimate of the proportion uninsured.

While we recognize that there are some limitations in reporting progress in this way, given the turnover in the caseload and the comparison of historical data about the uninsured to current enrollment data, we are fortunate in Wisconsin to have this baseline population data. The Wisconsin Family Health Survey data presents a more accurate picture of the uninsured in Wisconsin than national studies or Census Bureau surveys. We believe it stands as a national model for its methodology and consistency, in part because it uses a larger sample, and asks more direct questions about insurance status than other instruments.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

Using the previous estimated baseline of 54,000 low-income uninsured children, BadgerCare still addresses over 100 percent of the need.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: **List your State's strategic objectives for your SCHIP program, as specified in your State Plan.**

Column 2: **List the performance goals for each strategic objective.**

Column 3: **For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.**

Note: ***If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "N/C" (for no change) in column 3.***

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		

TABLE 1.3		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
BadgerCare enrollees will report satisfaction with access to care in terms of waiting time for appointments, ability to get referrals, etc.	BadgerCare HMO enrollees will report the same level of satisfaction with access to care, based on standard indices, as TANF/ Healthy Start Medicaid HMO enrollees	N/C Data Sources: CAHPS® Survey performed by 3rd party contractor in late CY 1999 and early CY 2000. Methodology: In CY 1999-2000, the CAHPS Survey for Medicaid HMOs sampled AFDC-related/Healthy Start Medicaid HMO enrollees. BadgerCare HMO enrollees could not be included in the sample because the required enrollment criteria could not be met in time for the survey to be administered. However, the HMOs that serve AFDC/HS populations that were sampled are the same as those serving BadgerCare. The CAHPS® survey will be administered again in late CY 2001, with this survey including BadgerCare enrollees. Numerator: Composite indices for enrollee satisfaction with access for separate AFDC-Related/Healthy Start Medicaid HMO enrollee and BadgerCare HMO enrollee samples. Denominator: Not relevant Progress Summary: The Executive Summary Report of the CY 1999-2000 CAHPS® survey is available on the Wisconsin DHFS web site at: http://www.dhfs.state.wi.us/medicaid1/recpubs/cahps/cahps.htm.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
OTHER OBJECTIVES:	***Quality of Care –Preventive and Chronic Disease State Care Performance Measures*** ***Targeted Performance Improvement Measures***	
Childhood immunizations	90% of enrolled children will be fully immunized by age 2 years.	N/C Data Sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: 3 Hep. B, 4 DTaP/DTP/DT, 2 Hib, 3 IPV (or OPV for 1999 services only–IPV only for services in 2000), and 1 MMR, each reported as individual numerators, contraindicated items can automatically be excluded. Combination rate including the following: 3 Hep. B, 4 DTaP, 2 Hib, 3 IPV/OPV, 1 MMR. Child must have different dates of service in the reporting year. At least one of the Hepatitis B vaccinations must fall on or between the child's sixth month and second birthday. Denominator: All children enrolled on their second birthday, with the second birthday falling in the reporting year and at least ten months of continuous enrollment with not more than one break in enrollment of 45 days prior to the child's second birthday and who received the required immunizations. Progress Summary: Measure specifications completed. This is a modification from the previous measure, updating the numerators to reflect current CDC-ACIP recommendations and with revised enrollment criteria in the denominator. Data for CY 2000 is available.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Lead Toxicity	2000: 65% of all eligible enrollees to have had lead toxicity screenings. The objective for CY 2001 is 85%. Two rates must be reported, one for one year olds and one for two year olds.	N/C Data Sources: Encounter data, medical records, public health screening data. Methodology: Service utilization measure. Numerator: The number of children in the denominator who had a blood lead screening performed by age one and age two years. Criteria: a) encounter with CPT-4 code 83655 or, b) medical record review data indicating blood lead test. Denominator: **L-1 Denominator for lead screening (For children from 6 to 16 months of age, inclusive)**: Any child that turned 16 months of age (inclusive to the last day of the sixteenth month) during the reporting year and was enrolled in the HMO at their first birthday and had ten months continuous enrollment with no more than one break in enrollment of up to 45 days prior to reaching 16 months of age. **L-2 Denominator (For children from 17 to 28 months of age, inclusive)**: The number of children 17 to 28 months (inclusive) of age who had their second birthday during the reporting year and were enrolled in the HMO at their second birthday with ten months continuous enrollment with no more than one break in enrollment of up to 45 days prior to reaching 28 months of age. The age cohort for this measure begins with the first day of the seventeenth month of life and includes the time period up to the last day of the 28th month of life. Progress Summary: Revised age cohort specifications implemented for 2000-01 HMO contract. Data for CY 2000 is available.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Preventive dental care.	For CYs 2000 and 2001 enrollees will receive preventive dental services at a rate greater than or equal to 110% of the preventive dental services rate for FFS recipients. Comparative preventive dental service rates are reported in the Wisconsin Medicaid Comparison Report: 1996.	N/C Data Sources: Encounter data or medical records. Methodology: Utilization measure. Numerator: The number of enrollees age 3 to 21 and age 21 and over who have had at least one preventive dental service during the reporting year, separated by county of residence of the enrollee. A member is identified as having a dental visit if he or she has had a claim/encounter that includes both a clinical oral evaluation and prophylaxis as defined by the following CDT-2 Current Dental Terminology (CDT) codes. Denominator: The number of children age 3 to 21 and age 21 and over enrolled in the HMO during the reporting year. Progress Summary: Baseline year for performance standard revised for implementation in 2000-2001 HMO contract. Data for CY 2000 are available.
Follow-up care after inpatient mental health care.	Improve rate of follow-up care by 7 and 30 days post discharge by 10% over baseline year (2000) in 2001. This improvement goal is based on a 10% improvement in adverse outcomes.	N/C Data Sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: The number of discharges in the denominator that were followed by an ambulatory mental health encounter or day/night treatment within 7 and 30 days of hospital discharge. Ambulatory follow-up encounters are identified by the CPT-4 codes or UB-92 revenue codes specified. Denominator: Discharges for enrollees age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified below, and who were continuously enrolled without breaks for 30 days after discharge. Progress Summary: Data for Baseline CY 2000 are available.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Follow-up care after inpatient treatment for substance abuse.	To increase the rate of ambulatory follow-up treatment within 7 and 30 days of discharge for individuals with specific substance abuse disorders, by 10 percentage points each year. This improvement goal is based on a 10% improvement in adverse outcomes	N/C Data Sources: Encounter data, medical record review. Methodology: Utilization measure. Numerator: The number of discharges in the denominator that were followed by an ambulatory substance abuse encounter within 7 and 30 days of discharge. Denominator: Discharges for enrollees age six years and older at the time of discharge who have been hospitalized with a discharge date occurring during the first 335 days of the reporting year and a principal ICD-9-CM diagnosis code indicating substance abuse, and who were continuously enrolled without breaks for 30 days after discharge. Progress Summary: Data for baseline CY 2000 are available.

Table 1.3		
QAPI SYSTEMS		
Strategic Objective	**Performance Goals**	**Performance Measures and Progress**
Outpatient Management of Diabetes	To measure and improve performance of outpatient management services for people with Type 1 or Type 2 diabetes. The goal for 2000 is establishment of baseline data for the provision of the following services to enrollees with diabetes: Hemoglobin A1c (HbA1c) testing, CPT-4 code 83036; and, Lipid profile testing, CPT-4 code 80061, 83720 or 83721.	N/C Data Sources: Encounter data, medical record review. Methodology: Utilization measure. Numerators: **Hemoglobin A1c:** HbA1c tests conducted in the reporting year. Administrative data or medical record review may be used to identify services. CPT-4 code 83036 or medical record lab report including result for service provided in the reporting year. **Lipid profile:** LDL test done during the reporting year or year prior to the reporting year. Administrative data or medical record review may be used to identify services. CPT-4 code 80061, 83720 or 83721 or medical record lab report including result. Denominator: Enrollees age 18-75 years as of December 31 of the reporting year. Must be continuously enrolled for ten months with no more than one gap in enrollment of 45 days in the reporting year. Those who were dispensed insulin and/or oral hypoglycemics/antihyperglycemics during the reporting year on an ambulatory basis, or had at least two encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one encounter in an acute inpatient or emergency room setting during the reporting year with diagnosis of diabetes. Progress Summary: Data for baseline CY 2000 are available.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Access to services and other utilization measures*** ***Clinical and non-clinical priority areas.***		
Clinical priority areas	Performance goals may be set by the HMO.	N/C Clinical priority areas are those identified by the state in the contract that the HMO may choose to measure and implement performance improvement projects in. Optional clinical topic areas include: 1. prenatal services; 2. identification of adequate treatment for high-risk pregnancies, including those involving substance abuse; 3. evaluating the need for specialty services; 4. availability of comprehensive, ongoing nutrition education, counseling, and assessments; 5. Family Health Improvement Initiative: Smoking Cessation; 6. children with special health care needs; 7. outpatient management of asthma; 8. the provision of family planning services; 9. early postpartum discharge of mothers and infants; 10. STD screening and treatment; and 11. high volume/high risk services selected by the HMO. Progress Summary: CY 2000 performance improvement project reports were received from all HMOs in October 2001.
Non-clinical priority areas	Performance goals may be set by the HMO.	N/C Non-clinical priority areas are those identified by the state in the contract that the HMO may choose to measure and implement performance improvement projects in. Optional non-clinical topic areas include: 1. Grievances, appeals and complaints; and 2. Access to and availability of services. In addition, the HMO may be required to conduct performance improvement projects specific to the HMO and to participate in one annual statewide project that maybe specified by the Department. Progress Summary: CY 2000 performance improvement project reports were received from all HMOs in November 2001.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Enrollee satisfaction***		
CAHPS® survey of BadgerCare HMO enrollee satisfaction.	Aggregation of baseline data on overall satisfaction. BadgerCare HMO enrollee satisfaction will be equivalent to TANF/Healthy Start HMO enrollee satisfaction	N/C CAHPS® survey implemented by third-party contractor. Progress Summary: The Executive Summary Report of the CY 1999-2000 CAHPS® survey is available on the Wisconsin DHFS web site at: http://www.dhfs.state.wi.us/medicaid1/recpubs/cahps/cahps.htm.
Satisfaction with referral for mental health/substance abuse care subset.	Aggregation of baseline data on overall satisfaction with referral for MH/SA services. BadgerCare HMO enrollee satisfaction will be equivalent to TANF/Healthy Start HMO enrollee satisfaction	N/C This performance improvement area establishes a baseline measure of enrollee satisfaction with referral for mental health and substance abuse services based on enrollee responses to the following specific questions. These questions will be included in the standardized Consumer Assessment of Health Plan (CAHPS®) survey administered by the Department. This measure assesses the number of enrollees indicating they "need help with an alcohol, drug or mental health problem" as the denominator and the number of enrollees that indicate they did or did not actually get counseling or help as the numerator. The results will be aggregated by the Department or its contractor and reported to the respective HMO. The Department may specify minimum performance levels and require that HMOs develop action plans to respond to performance levels below the minimum performance levels. Progress Summary: The Executive Summary Report of the CY 1999-2000 CAHPS® survey is available on the Wisconsin DHFS web site at: http://www.dhfs.state.wi.us/medicaid1/recpubs/cahps/cahps.htm.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Standardized utilization survey measures***		
Women's health measures: maternity care.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks number of all deliveries with live birth and inpatient days by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All C-section and vaginal deliveries with live birth. Denominator: Not applicable. Not reported as a percentage Progress Summary: Measure is implemented.
Women's health measures: C-sections.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks number of deliveries by Cesarean section with live birth and inpatient days by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All C-section deliveries with live birth. Denominator: All live births. Progress Summary: Measure is implemented.
Women's health measures: VBAC.	Trend and monitor utilization, LOS after delivery. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number of vaginal births after Cesarean section (VBAC) with live birth and inpatient days by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Vaginal deliveries after previous C-section. Denominator: All live births. Progress Summary: Measure is implemented.
Women's health measures: substance abuse treatment concurrent with pregnancy/ delivery	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number of women who delivered live birth and had substance abuse services. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All deliveries with live birth for enrollees receiving SA services in the 300 days prior to delivery. Denominator: Not applicable. Not reported as a percentage

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE *Standardized utilization survey measures*		
		Progress Summary: Measure is implemented. Data for first 6 months of CY 2000 in Utilization/ Survey report available in November 2000; encounter data in CY 2000 is available monthly, beginning May 2000 (retroactive to January 2000)
Women's health measures: HIV testing at delivery.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks number of women who delivered live birth and had HIV testing. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: All deliveries with live birth for enrollees receiving HIV testing in the 300 days prior to delivery. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Women's health measures: mammography.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number women that had a mammogram in the reporting year by age cohort. Measure includes numerator for number of women with malignancy of the breast. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator(s): Female enrollees receiving at least one mammogram. Number of tests detecting malignancy. Denominator: Unduplicated female enrollees by age cohort. Progress Summary: Measure is implemented.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE *Standardized utilization survey measures*		
Women's health measures: Pap test (cervical cancer screening).	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number women that had a Pap test in the reporting year by age cohort. Measure includes numerator for number of women with malignancy of the cervix and/or uterus. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Female enrollees receiving at least one Pap test. Number of tests detecting malignancy. Denominator: Unduplicated female enrollees by age cohort. Progress Summary: Measure is implemented.
Child health measures: HealthCheck screens.	Trend and monitor utilization. Goal: 80% of eligible children under age 21 receive required screens. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of children that received a comprehensive HealthCheck screening by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Number of unduplicated children under age 21 that received at least one comprehensive HealthCheck. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Child health measures: HealthCheck screens.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks number children referred for follow-up care as the result of HealthCheck screens, excluding vision, dental and audiology services by age cohort under age 21 years. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Children referred for follow-up care as the result of HealthCheck screens, excluding vision, dental and audiology services by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE *Standardized utilization survey measures*		
Child health measures: well-child non-HealthCheck screens.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of children that received a child health non-HealthCheck screening by age cohort under age 21 years. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: The number of children that received a child health non-HealthCheck screening by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Child health measures: other non-HealthCheck ambulatory health services.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of children that received a non-HealthCheck ambulatory health service by age cohort under age 21 years. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: The number of children that received a non-HealthCheck ambulatory health service by age cohort under age 21 years. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Child health measures: number of children with diagnosis of asthma.	Trend and monitor prevalence. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees under age 21 years with diagnosis of asthma in the reporting period. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees under age 21 years with diagnosis of asthma. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE ***Standardized utilization survey measures***		
Child health measures: number of children with at least one inpatient stay for a diagnosis of asthma.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts	Tracks the number of unduplicated enrollees under age 21 years with at least one inpatient stay for a diagnosis of asthma in the reporting period. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees with at least one inpatient stay for a diagnosis of asthma. Denominator: All enrollees under age 21 years with diagnosis of asthma. Progress Summary: Measure is implemented.
Mental health/ substance abuse: outpatient evaluations.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving outpatient mental health and/or substance abuse evaluations by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving outpatient mental health and/or substance abuse evaluations. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Mental health/ substance abuse: outpatient treatment.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving outpatient mental health and/or substance abuse treatment by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator(s): Unduplicated enrollees receiving outpatient mental health and/or substance abuse treatment. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE *Standardized utilization survey measures*		
Mental health/ substance abuse: inpatient readmissions for treatment.	Trend and monitor prevalence and utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving inpatient mental health for the same diagnosis within one-year by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving inpatient mental health for the same diagnosis within one year. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Primary and Specialty care: ER visits without inpatient admission.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in an emergency department of an acute care hospital not resulting in an inpatient admission by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in an emergency department of an acute care hospital not resulting in an inpatient admission. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Primary and Specialty care: Home care	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in a home care setting by age cohort. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in a home care setting. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.
Primary and Specialty care: Care in a primary care clinic, vision care, audiology, and dental clinic.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in each listed care setting. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in each listed care setting. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.

OTHER OBJECTIVES: ACCESS TO CARE/USE OF PREVENTIVE CARE/ QUALITY OF CARE *Standardized utilization survey measures*		
Hospital utilization data: number of discharges, ALOS, total hospital days, for maternity, surgical, medical, psychiatric and AODA services.	Trend and monitor utilization. BadgerCare HMO enrollee utilization equivalent to TANF/Healthy Start HMO enrollee utilization for similar age/sex cohorts.	Tracks the number of unduplicated enrollees receiving care in an inpatient acute care hospital setting for each listed care type. Data Sources: Encounter data; Utilization/Survey Data. Methodology: Utilization measure. Numerator: Unduplicated enrollees receiving care in an inpatient acute care hospital setting for each listed care type. Denominator: Not applicable. Not reported as a percentage. Progress Summary: Measure is implemented.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Performance goals relating to reducing the number of uninsured children, SCHIP enrollment, and increasing Medicaid enrollment have been met. Enrollment of children in BadgerCare increased by 25.4 percent during the FFY. Enrollment of adults in BadgerCare increased by approximately 20 percent during the same period.

While overall enrollment in BadgerCare increased, enrollment in Medicaid/BadgerCare HMO's remained constant at 69 percent. This reflects HMO enrollment which is nearly identical to the previous reporting period. Therefore, numerically, more BadgerCare recipients are enrolled in HMO's as compared to the previous reporting period.

Performance goals relating to access to health care have been met, since 69 percent of BadgerCare recipients are enrolled in Medicaid/BadgerCare HMOs and the Wisconsin Medicaid/BadgerCare Managed Care program has a history of providing increased access to services compared to fee-for-service.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

HMO Encounter Data has been validated for reliability and completeness for CY 2000 and will be used to measure access to care and quality of care.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

The following are future performance measurement activities relating to BadgerCare:

- CY 2000 HMO BadgerCare Survey/Utilization Report and Targeted Performance Improvement Measures, which report data on indicators used to measure access to care and quality of care. Final reports from HMOs were submitted in November 2001.

- Employer survey to measure extent, if any, of "crowd-out" due to BadgerCare. Survey to be performed in early 2002 and completed in late 2002.

- Ongoing HMO performed clinical care studies, DHFS medical care audits, etc. that are components of Managed Care Quality Assurance/Performance Improvement (QAPI) program.

- The 2000 HMO/FFS Ambulatory Quality of Care Review implementation began in October 2000. This review is being conducted by the state's External Quality Review Organization (MetaStar). The preliminary report by the EQRO was delivered in the last week of August, 2001 and review of the results is continuing.

- The Department has developed draft technical specifications for MEDDIC-MS, Wisconsin's new managed care performance measure set. MEDDIC-MS, the Medicaid Encounter Data Driven Improvement Core Measure Set, is driven by HMO encounter data. Testing and refinement of the measure set is underway and will continue into CY 2002.

- The HMO Report Card for consumers was completed in June 2001. Preparation for distribution to new enrollees through the new enrollee packet and possibly other means such as the Internet will occur in 2002, with implementation of the new 2002-03 contract.

  The HMO Report Card compares participating HMOs on their performance on five clinical and four satisfaction topics. Each HMO is given a rating of one to three stars on each topic. One star indicates that the HMO's performance was below the average performance level of all the participating HMOs. Two stars indicate HMO performance equal to the average and three stars indicates above average performance.

- A draft new enrollee health needs screening tool was completed in CY 2001 and implementation of the tool is currently in the testing phase. The screening tool is designed to assist HMOs with performing outreach to new enrollees, identification of enrollees with special healthcare needs and expediting delivery of health services.

- The Department's annual "Best Practices in Managed Health Care" symposium was held on June 20, 2001.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

A study on eligibility outstationing has been conducted. Data is being complied and analyzed regarding: customer service; customer and provider satisfaction; public education including

public service announcements via television and radio; and training of providers. An increase in Medicaid caseload is correlated with these outreach efforts. A report on the findings of the study will be available in 2003.

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family Coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

Low-income uninsured families who are not eligible for Medicaid qualify for BadgerCare if family income is below 185 percent of the federal poverty level. Families remain eligible for BadgerCare until their income reaches 200 percent of the federal poverty level. No asset test is required to enroll in BadgerCare. Families that have insurance currently or in the past three months, or have access to a group health insurance plan in which their employer pays at least 80 percent of the monthly premium, are not eligible for BadgerCare.

Most BadgerCare families are enrolled in the Wisconsin Medicaid managed care Health Maintenance Organization (HMO) program. However, BadgerCare can pay premiums to enroll families into their employer-sponsored health insurance. To qualify for the Health Insurance Premium Purchase (HIPP) program, the employer must pay at least 40 percent, but less than 80 percent, of a family premium. In addition, the cost of the family premium, plus wraparound services equal to BadgerCare coverage, must be cost-effective compared to BadgerCare HMO coverage for the family. As of November 1, 2001, 49 families were enrolled in HIPP.

Families with an income above 150 percent of the federal poverty level pay a premium equal to 3 percent of their income.

To guard against possible crowd-out issues, BadgerCare applicants currently covered by health insurance, or who have been covered in the last three months prior to the month of application, and who have a health insurance policy that meets the definition of the Health Insurance Portability and Accountability Act (HIPAA) are ineligible for BadgerCare. Applicants who have access to health insurance offered by an employer are also ineligible for BadgerCare; this requirement applies to access to coverage available at anytime within the 18 months prior to the employer must cover dependents, and the employer must pay at least 80 percent of the cost of coverage. Administrative rules do specify good cause exceptions to BadgerCare's insurance access and coverage restrictions.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (October 1, 2000 – September 30, 2001)?

130,954	**Number of adults**
68,523	**Number of children**

C. How do you monitor cost-effectiveness of family coverage?

Wisconsin determines the cost of participation in the employer family coverage plan and measures it against the per member, per month managed care cost for BadgerCare. We also monitor the actual costs on a retrospective basis.

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

The Wisconsin Medicaid fiscal agent, receives daily notifications of the employment status of new and ongoing BadgerCare recipients from the state's eligibility determination (CARES) system. Medicaid fiscal agent staff contact the employers of all applicants to verify current access to family health insurance subsidized by the employer. Verification is done through mailing of the Employer Verification of Insurance Coverage (EVIC) forms to the employers and telephone follow-up.

The Health Insurance Premium Payment (HIPP) Program – Cost-Effectiveness Test.

At this point, the Medicaid fiscal agent has received verification that the family has access to employer-subsidized family health care coverage, subsidized at less than 80 percent but more than 40 percent of the premium cost. The family is made BadgerCare eligible on a FFS basis. The next step is to determine whether it is cost-effective to buy them into the available employer-sponsored insurance through the HIPP Program or through the Title XXI cost-effectiveness test. If it is not cost-effective, the family chooses between the BadgerCare HMO programs available to recipients living in their service area or remain in BadgerCare FFS if no HMOs are available. If only one HMO is available the family has a choice between choosing to enroll in the HMO or remaining in FFS.

Employers are contacted to obtain specific information about their insurance plans so that:

- Cost effectiveness can be determined. The Medicaid fiscal agent determines the cost of the family premium, how much the employer pays, and what types of services the plan covers.

- Premium payments can be made. The Medicaid fiscal agent determines whether the employer, insurer or recipient will be reimbursed, as well as frequency and payment method.

- Full insurance information is added to the recipient's eligibility record for coordination of benefits activities in claims processing. This information includes group and subscriber numbers, begin and end dates of coverage and indicators of services covered by the plan.

- The following information is collected and retained in the HIPP Program database:

  - Length of employer health insurance coverage;

  - Employer payment frequency and method of payment;

  - Premium amounts;

  - Employer contribution amounts and coverage; and

  - Who is covered under the insurance.

- BadgerCare families in Wisconsin are only eligible to participate in HIPP if:

  - They had no employer-sponsored group coverage within the previous six months (exceptions are allowed if prior coverage was involuntarily terminated by other than the current employer), and

  - The employer contributes at least 40 percent, but less than 80 percent, of the premium share for family coverage (families whose employer contributes more than 80 percent of the premium share are not eligible for BadgerCare).

- When the information needed for the cost-effectiveness determination is received, the cost effectiveness comparison is made between:

  - The cost of BadgerCare HMO enrollment for the children (plus certain additional services covered on a FFS basis, such as family planning, dental, or chiropractic), up to the full Medicaid level of services; and

  - The cost of the BadgerCare portion of the employer-subsidized insurance premium (including the cost of co-insurance and deductible reimbursement to the providers), plus the cost of wraparound services to provide the full Medicaid level of services. In addition, the state includes administrative costs for data collection, processing, notifications, telephone charges and other

maintenance costs of the HIPP process in its cost effectiveness calculation.

- If cost of ESI is less than enrollment of children only in BadgerCare, the state claims cost for purchase of ESI under Title XXI for adults (71 percent of cost).

Another calculation is made to compare costs of ESI vs. enrollment of the family in BadgerCare. If ESI is less expensive than enrollment of adults in BadgerCare, the state also claims cost for purchase of ESI under Title XXI for adults.

The Health Insurance Premium Payment (HIPP) Program - Benefits equivalency, Limitation on Copayment Liability, Coordination with CHIP

Benefit Equivalency: BadgerCare recipients receive the full range of Wisconsin Medicaid covered services. BadgerCare recipients enrolled in employer-sponsored insurance through HIPP also receive the full range of Wisconsin Medicaid covered services. Recipients enrolled in ESI receive BadgerCare services on a FFS basis from Medicaid providers for those services not covered by the ESI or services covered by the ESI but for which maximum limits have been reached. This is called "wraparound."

Limitation on Copayment Liability: BadgerCare recipients enrolled in employer-sponsored insurance through HIPP do not pay for the coinsurance and deductibles charged by the ESI. ESI providers submit claims for coinsurance and deductibles to the Medicaid fiscal agent, the Wisconsin Medicaid fiscal agent, which are then paid on a FFS basis. BadgerCare recipients enrolled in employer-sponsored insurance are required to pay the standard Medicaid copayments, which are nominal. Medicaid copayments are only applied to non-pregnant adults; in addition, certain services are exempt from copayments which include emergency services, family planning services/supplies, therapies over the Medicaid prior authorization limit, and other essential services.

Coordination with CHIP: The family is enrolled in the employer-provided family health insurance plan at the earliest available open enrollment period of the health plan. If the earliest available open enrollment period is less than six months in the future, the family receives benefits in BadgerCare FFS until they can be enrolled in the employer-provided family health insurance plan. If the earliest available open enrollment period is six or more months in the future, the family is enrolled in the Medicaid HMO program until they can be enrolled in the employer-provided family health insurance plan.

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

61 **Number of adults**

107 **Number of children**

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

BadgerCare is intended to help families in the workforce receive affordable health insurance until they can obtain insurance from their employment. BadgerCare eligibility policies are designed specifically to prevent supplanting or "crowd-out" of private insurance.

Crowd-out may occur in the following situations:

- Families drop employer-sponsored coverage as a direct result of the extension of BadgerCare (subsidized coverage not previously available).
- Families enrolled in BadgerCare choose to remain in BadgerCare despite access to employer-sponsored coverage.
- Employers reduce or drop their contribution to family coverage in direct response to BadgerCare eligibility policies.

B. How do you monitor and measure whether crowd-out is occurring?

System edits and protocols in CARES and MMIS monitor and prevent BadgerCare enrollment of families with the following:

- current HIPAA coverage;
- coverage in the three months prior to application;
- current access to ESI subsidized by the employer at 80 percent or more of premium costs;
- access in the 18 months prior to application; or
- direct applicant eligibility to HIPP enrollment if covered by ESI subsidized by the employer between 40 and 80 percent of the monthly premium.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

We know of no evidence that BadgerCare is causing employers to drop insurance coverage.

During October 2000 until September of 2001, individuals terminated from BadgerCare due to access to employer insurance included 94 adults and 166 children. During the

same period, individuals denied or terminated because of major medical health insurance coverage included 27,474 adults and 46,358 children.

The 2000 Family Health Survey *Wisconsin Health Insurance Coverage* report was recently released, showing a stable trend in health insurance coverage over recent years. The proportion of residents who were uninsured for an entire year has remained steady since 1998, at 4 percent. Another 7 percent of Wisconsin residents were uninsured for part of the year in 2000, compared to 8 percent in 1999 and 6 percent in 1998. The decrease from 8 percent in 1999 to 7 percent in 2000 is the only statistically significant change in the year 2000 insurance measures reported here. In 2000, the remaining 88 percent were insured for the entire 12-month period.

Looking at insurance status at one point in time, the 2000 survey found 94 percent of Wisconsin household residents were insured at the time of the survey, compared to 93 percent in 1999 and 94 percent in 1998. In 2000, 6 percent were uninsured at a point-in-time. A copy of the 2000 insurance coverage report is located on the web at: www.dhfs.state.wi.us/stats/healthinsurance.htm (See first report on the web page.)

Among residents of low-income households (total income below 200 percent of the federal poverty level) with children present, 12 percent were uninsured at a point-in-time during 2000. This was a total of 100,000 uninsured residents, including 39,000 children and 61,000 adults. Among low-income children, 10 percent were uninsured at a point-in-time, while among low-income adults who lived in a household with at least one child, 16 percent were uninsured.

A comparison of low-income-residents' health insurance coverage using Family Health Survey data for 1998 and 2000 shows several important changes. (BadgerCare started mid-1999, so 1998 data are a pre-BadgerCare measure and 2000 data are post-BadgerCare. Low-income is defined as household income below 200 percent of the federal poverty guideline.)

- The estimated number of low-income Wisconsin residents decreased substantially from 1998 to 2000 (from 927,000 to 808,000), reflecting the overall strong economic climate.

- The estimated percentage of low-income residents enrolled in any Medicaid program (including BadgerCare) increased significantly. Among children, 24 percent were enrolled in 1998 and 34 percent in 2000. Among adults, 12 percent were enrolled in 1998 and 21 percent in 2000. Both of these groups also showed numeric increases in Medicaid enrollment.

- The estimated percentage of low-income children or adults with employer-group health insurance did not show a statistically significant change from 1998 to 2000, although there was a small decrease in the percent covered by employer-group

insurance from 1998 to 2000.

- Thus, although the estimated percentage of low-income residents enrolled in Medicaid increased significantly, there was not a corresponding statistically significant decrease in the percentage of low-income children or adults with employer-group health insurance.

- The estimated percentage of low-income children or adults who were uninsured did not show a statistically significant change from 1998 to 2000. (The percentage of uninsured low-income children increased slightly from 1998 to 2000, but the change was not statistically significant.)

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

BadgerCare eligibility is limited to families whose income does not exceed 185 percent of the FPL. Very few families with income at this level have access to private health coverage. The attached "EVIC Statistics Analysis" indicates a small number of BadgerCare recipients have access to employer-sponsored insurance where the employer contributes between 60 to 80 percent of the monthly premium. (Effective November 1, 2001, Wisconsin received approval of a State Plan Amendment allowing an employer threshold of 40 percent vs. 60 percent. The EVIC Analysis is based on a 60 percent threshold.)

Once eligible, families may remain in BadgerCare until their income exceeds 200 percent of the FPL. Employer-subsidized health insurance is not common among families with income at or below these amounts.

The State performs research to determine if a BadgerCare family should be enrolled in the HIPP or if a family member has access to a family group health plan where the employer pays 80 percent or more of the premium.

BadgerCare crowd-out policies are publicized using a variety of media and access points. Television and radio spots were initially used to familiarize people with the general concept of BadgerCare. An ongoing, extensive distribution of program brochures to counties, health care facilities, employment agencies, employers and eligibility determination sites provides a source of BadgerCare crowd-out policy and eligibility information. In addition, a toll-free telephone hotline has been established to respond to specific eligibility and application questions.

Employer training sessions on BadgerCare policy and eligibility have been conducted in conjunction with private employer associations for the purpose of explaining crowd-out policy and the HIPP program. We have also provided training to staff of community agencies and advocacy agencies on these policies so that they can help explain program requirements to their customers.

BadgerCare crowd-out policy and eligibility information is continuously available on the BadgerCare web site, including, employer fact sheets and eligibility criteria for families with access to employer-sponsored coverage.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Some of the more successful outreach projects are:

1. Outstationing of eligibility staff and FQHC outstationing expansion.

2. Training efforts for BadgerCare provided useful information for social service agencies for eligibility decisions and provided community groups the information to deliver effective outreach.

3. Name change important. This change sent a message to new applicants that health insurance for low income working families was no longer associated with welfare.

4. Television promotion at program start-up.

5. Outreach efforts for all family members. The BadgerCare policy that provides coverage for parents as part of the program has created an additional incentive to bring new families into the application process.

The methods and indicators used to assess outreach effectiveness are:

1. Medicaid Caseload growth – Since implementation in July 1999, the number of individuals in the Medicaid/BadgerCare program increased by 100,000 from June 1999 – February 2001.

2. Telephone data from customer 800 number calls – The major sources of customers calls for BadgerCare information were:

   - 40 percent of the callers learned about the program from a television ad;
   - 26 percent from friends/relatives;

- 11 percent from a notice put on the previous month's Medicaid card; and
- 8 percent from their caseworkers.

3. Television Data – The ad reached over 90 percent of the target audience, adults ages 25 – 45. During the first three months of BadgerCare implementation the Milwaukee BadgerCare hotline logged over 8,000 calls. When asked how they heard about BadgerCare, about 34 percent responded that they had seen the ad on television, the single largest response group.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Dane County Department of Human Services, in partnership with the Dane County Health Council, and the Department of Health and Family Services is conducting a two-year project to improve access to Medicaid/BadgerCare by: piloting simplified applications and reviews and conducting outreach for target groups, focusing on the growing Latino population in Dane County.

The following processes are part of an ongoing evaluation process initiated with this project:

1. Customer Service – Assessment of a simplified, mail-in application is being evaluated with a mailing and/or telephone call to a sample of recipients to assess the quality of these enhancements.

2. Program Integrity – Measurement of the effect on program quality that self-declaration of income, residence, etc. as compared to current system requiring third-party verification of financial and non-financial eligibility factors.

3. Increasing Program Efficiency – As Medicaid/BadgerCare case processing is simplified, it is assumed administrative savings will be realized at the local level. During the course of implementation of this project an evaluation is being conducted to assess this effect on program administration.

4. Targeted Outreach and Improved Access – This outcome is being measured as the project is implemented.

5. Network Building – The impact of this effort and improved linkage at the local level is being assessed as part of the project.

C. Which methods best reached which populations? How have you measured effectiveness?

In addition to the Dane County project, the Department is working with The Covering Kids Coalition to assess consumer satisfaction, through customer surveys. The surveys are being conducted throughout the implementation of program simplification.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

BadgerCare now has a mail-in application/review process, with a 12-month review period.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

____ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population: _____
____ Information campaigns
__X__ Simplification of re-enrollment process, please describe: _____
____ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe: _____
____ Other, please explain: _____

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes, both Medicaid and BadgerCare use an integrated eligibility system.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

The Medical Assistance eligibility cascade within the CARES system tracks children's eligibility regularly. In addition, the fact that BadgerCare covers children and their parents has also helped keep children enrolled.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

The CARES MMIS system is currently being modified to better capture this information. Data will be available in 2003.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, a single application process is used for both programs. Wisconsin uses an automated eligibility determination system that checks for all Medicaid subprogram eligibility for children and parents, and for any child or parent not eligible in those programs the system checks for BadgerCare eligibility.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

This process happens any time that eligibility is determined in the automated system.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes. We use the same provider networks and other delivery systems for Medicaid and SCHIP.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

N/C

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

N/C

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

- See Table 1.3.

- The Executive Summary Report of the CY 1999-2000 CAHPS® survey is available on the Wisconsin DHFS web site at: http://www.dhfs.state.wi.us/medicaid1/recpubs/cahps/cahps.htm.

- The 1998-1999 HMO Comparison Report is available on the DHFS web site at: http://www.dhfs.state.wi.us/Medicaid/index.htm

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

See Table 1.3.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

See 1.6.

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Reduced verification requirements.

B. Outreach

Statewide network building with Covering Kids grantee as lead.

C. Enrollment

Family Medicaid/BadgerCare enrollment increase of 64 percent.

D. Retention/disenrollment

The Division of Health Care Financing is in the process of developing a tool to analyze retention and enrollment data.

E. Benefit structure

N/C

F. Cost-sharing

N/C

G. Delivery system

N/C

H. Coordination with other programs

N/C

I. Crowd-out

Modified HIPP buy-in percent for employer insurance (40%).

J. Other

Customers notice improvements implemented in February 2001.

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts October 1, 1999 and ends September 30, 2000.

	Federal Fiscal Year 2001 Costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments	10,000	12,000	14,000
Managed care	58,398,300	62,878,600	65,392,500
Per member/per month rate X # of eligibles	124.80	131.95	137.13
Fee for Service	26,654,200	32,068,400	32,957,200
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)	(2,152,200)	(2,994,400)	(3,293,400)
Net Benefit Costs	82,900,300	91,952,600	95,056,200
Administration Costs			
Personnel	100,269	125,000	150,000
General administration	4,875,770	7,000,000	7,200,000
Contractors/Brokers (e.g., enrollment contractors)	23,961	25,000	30,000
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	5,000,000	7,150,000	7,380,000
10% Administrative Cost Ceiling	9,690,500	10,883,700	11,292,200
Federal Share (multiplied by enhanced FMAP rate)	62,848,700	70,858,359	73,241,883
State Share	25,051,600	28,244,241	29,194,317
TOTAL PROGRAM COSTS	87,900,300	99,102,600	102,436,200

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

For AFDC, Healthy Start and SCHIP coverage, the state spent $230,819,500 in SFY 2001 (July 2000 – June 2001).

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__ State appropriations
_____ County/local funds
__X__ Employer contributions (small amounts)
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
__X__ Other (specify): Premiums were charged at 3.0 percent for those with incomes above 150 percent FPL

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

Sources will not change, but dollar amounts will increase.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules.)

Table 5.1	Medicaid Expansion SCHIP Program	Separate SCHIP Program
Program Name		
Provides presumptive eligibility for children	__X__ No ____ Yes, for whom and how long?	____ No ____ Yes, for whom and how long?
Provides retroactive eligibility	__X__ No ____ Yes, for whom and how long?	____ No ____ Yes, for whom and how long?
Makes eligibility determination	____ State Medicaid eligibility staff ____ Contractor ____ Community-based organizations ____ Insurance agents ____ MCO staff __X__ Other *(specify):* State contracted county agencies who also do Medicaid/ automated system	____ State Medicaid eligibility staff ____ Contractor ____ Community-based organizations ____ Insurance agents ____ MCO staff ____ Other *(specify):*
Average length of stay on program	Specify months: 10	Specify months:
Has joint application for Medicaid and SCHIP	____ No __X__ Yes	____ No ____ Yes
Has a mail-in application	____ No __X__ Yes	____ No ____ Yes
Can apply for program over phone	____ No __X__ Yes	____ No ____ Yes
Can apply for program over internet	__X__ No ____ Yes	____ No ____ Yes
Requires face-to-face interview during initial application	__X__ No ____ Yes	____ No ____ Yes

Table 5.1	Medicaid Expansion SCHIP Program	Separate SCHIP Program
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No __X__Yes, specify number of months: _3__ What exemptions do you provide? _____	_____No _____Yes, specify number of months:_____ What exemptions do you provide? _____
Provides period of continuous coverage regardless of income changes	__X__No _____Yes, specify number of months:_____ Explain circumstances when a child would lose eligibility during the time period:_____ _____	___No _____Yes, specify number of months:_____ Explain circumstances when a child would lose eligibility during the time period:_____ _____
Imposes premiums or enrollment fees	_____No __X__Yes, how much? Who Can Pay? ____ Employer __X__ Family _____ Absent parent _____ Private donations/sponsorship _____ Other (specify):_____	_____No ____Yes, how much? (Varies by income, above 150% of FPL) Who Can Pay? _____ Employer _____ Family _____ Absent parent _____ Private donations/ sponsorship _____ Other (specify):_____
Imposes copayments or coinsurance	__X__No _____Yes	____No _____Yes
Provides preprinted redetermination process	__X__No _____Yes, we send out form to family with their information precompleted and: ___ Ask for a signed confirmation that information is still correct. ___ Do not request response unless income or other circumstances have changed.	___No _____Yes, we send out form to family with their information and: ___ Ask for a signed confirmation that information is still correct. ___ Do not request response unless income or other circumstances have changed.

5.2 Please explain how the redetermination process differs from the initial application process.

Wisconsin has implemented mail-in and phone-in options with the same reduced verification requirements that have been implemented for the initial application process.

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

185% of FPL for children under age 6
100% of FPL for children aged 6 to under 19
____% of FPL for children aged _____

Medicaid SCHIP Expansion

200% of FPL for children aged under 19
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

X Yes ___ No

If yes, please report rules for applicants (initial enrollment).
Applicant groups are tested against the 185 percent of poverty income test and recipient groups are tested against a 200 percent FPL income limit.

Table 6.2			
	Title XIX Child Poverty-related Groups	**Medicaid SCHIP Expansion**	**Separate SCHIP Program**
Earnings	$90	$90	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$50	$50	$
Paid	$	$	$
Child care expenses	$175/200	$175/200	$
Medical care expenses	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups
_X_ **No** ___**Yes, specify countable or allowable level of asset test**_____

Medicaid SCHIP Expansion program
_X_ **No** ____**Yes, specify countable or allowable level of asset test**_____

Separate SCHIP program
____ **No** ____**Yes, specify countable or allowable level of asset test**_____

Other SCHIP program_____
____ **No** ____**Yes, specify countable or allowable level of asset test**_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

_X_ **No** ___**Yes**

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(October 1, 2000 – September 30, 2001)? Please comment on why the changes are planned.

A. Family coverage

N/C

B. Employer sponsored insurance buy-in

The Current policy of the BadgerCare program allows employer buy-in when the employer share is no less than 40 percent and no greater than 80. Under this plan, the state has had limited success in leveraging the employer share of health insurance premiums for BadgerCare enrollees.

In response to the changes in the SCHIP regulations, in April 2001 the state submitted a draft State Plan Amendment to eliminate the minimum employer premium contribution and base purchase of employer coverage solely on cost effectiveness. CMS responded that Wisconsin needed to establish a minimum level of employer contribution. Wisconsin has received approval for a State Plan Amendment that will reflect a minimum 40 percent employer contribution.

Through September 30, 2001, 43 families have been enrolled in their employer-sponsored plan as part of the BadgerCare program. In addition, another 129 families have been determined to be cost effective for buy-in and are waiting open enrollment periods.

Wisconsin is also working on revisions to the Employer Verification of Insurance Coverage (EVIC) form to allow self funded health plans to be considered for BadgerCare HIPP.

C. 1115 waiver

N/C

D. Eligibility including presumptive and continuous eligibility

Wisconsin has implemented a mail-in/phone-in application and review process with reduced verification requirements for all Medicaid/BadgerCare customers. Wisconsin does not include presumptive or continuous eligibility for its SCHIP program.

E. Outreach

Medicaid and BadgerCare Outreach Summary

PROJECT	DESCRIPTION
Informing Materials	Medicaid and BadgerCare informing materials in Spanish, Hmong, Russian, including a variety of new fact sheets on the Internet. Posters and brochures are available in printed form, and brochures are on-line in PDF format in English, Spanish, Hmong, and Russian. Over 30,000 Spanish and Hmong brochures have been delivered since July 1999. BadgerCare brochure with Governor McCallum's photo is now at the printer.
"Covering Kids" Expansion	Robert Wood Johnson Foundation project in Wisconsin (one of 50 state projects) with ABC for Health as the project lead, and supplemental funding by DHFS, for statewide network building project with community organizations and health care providers as well as agencies that assist populations with language barriers. Project funded through June 2002.
Outstations	DHFS funding through December 2001 for eligibility outstations in Milwaukee and Kenosha Counties, for Medicaid & BadgerCare, Food Stamp and Child Care enrollments at community sites and health care facilities. Some other local IM agencies are using eligibility outstationing as part of their service delivery system.
School Outreach	Conducted in various districts, some connected with a sign-off on the free or reduced price lunch application, which allows the local social service agency to contact the family. In Milwaukee a back-to-school health fair was conducted in August. In addition, a Milwaukee Public School, County Department of Human Services enrollment pilot was conducted in the fall of 2000. A Medicaid application was attached to the free and reduced price lunch application form and mailed to 50,000 families. A response of 4,000 application forms resulted in several hundred new families to Medicaid or BadgerCare.
Program Simplification	Mail-in application and recertification with reduced verification requirements implemented in July 2001.
Training for Community Organizations	Automated Health Systems is providing statewide training to community organizations and health care providers on Medicaid and BadgerCare program simplification initiatives.

PROJECT	DESCRIPTION
"Dane County Connections" Phase II	A two-year project (through December 2002), funded by DHFS, Dane County, and local health care providers, to assist with outreach efforts for target groups, focusing on the growing Latino population in Dane County and provide enrollment assistance to other underinsured groups, including adolescents and higher income families. The project also assisted with the piloting of simplified application procedures and will share lessons learned for possible policy modification.
Focused outreach to three target groups – families: • whose primary language is not English • with income above 150% of the federal poverty level • with teenagers	All of the projects focus to some degree on all of the target groups. The revised BadgerCare brochure adds text and photos of teens, and text describing the benefits of paying a premium as an investment in family health. The Dane County project is focusing directly on limited English speaking families and program simplification changes are designed to improve service delivery to low-income working families.

F. Enrollment/Redetermination Process

Extensive training for community organizations and health care providers has been provided with the implementation of program simplification. In addition the statewide access network provided a great deal of assistance with coordinating the implementation of program simplification.

G. Contracting

There are no material changes planned for the 2002-03 contract. Changes made to the contract will reflect changes required as a result of CMS' August 20, 2001, Interim Medicaid Managed Care rule.

H. Other